Skidmore College EPO Medical Plan

Summary of Benefits

Service Category	In-Network Coverage	Limits and Exclusions
Annual Deductible per contract year	$200 Individual / $400 Family	None
Co-insurance	Not Applicable	None
Annual Out-of-Pocket Maximum	$1,500 Individual / $3,000 Family	Medical Only
Annual Out-of-Pocket Maximum	$7,600 Individual / $15,200 Family	Prescription Drug Only
Preventive & Well Care Services Well Child Care & Immunizations Adult Physical (One Routine Physical/Contract Year) Mammography Annual Pap Test & Ob/Gyn Exam Immunizations for Adults Colonoscopy & Sigmoidoscopy Screening (For Adults) Bone Density Tests	**Preventive & Well Care Services are covered in full.**	
Physician Office Visits (PCP/Specialist)	$25 PCP / $40 Specialist Copay After Deductible	None
OB/GYN Non-Routine Visits	$25 Copay After Deductible	None
Diagnostic Lab Services (Office)	Covered in Full After Deductible	None
Diagnostic X-ray (Office)	$40 Copay After Deductible	None
Advanced Imaging Services (Office – CT/PET scans, MRIs)	$40 Copay After Deductible	None
Rehabilitative Services (Office – PT/OT/ST)	$40 Copay After Deductible	None
Medical/Surgical Admissions (Inpatient Hospital)	$250 Copay After Deductible	None
Surgical Services (Inpatient Hospital)	Covered in Full After Deductible	None
Inpatient Physical Rehabilitation	$250 Copay After Deductible	None
Hospital Rehab Services (Outpatient – PT)	$40 Copay After Deductible	None
(Outpatient – OT)	$40 Copay After Deductible	None
(Outpatient – ST)	$40 Copay After Deductible	None
Diagnostic Laboratory Services** (Outpatient Hospital)	Covered in Full After Deductible	None
Diagnostic X-ray** (Outpatient)	$40 Copay After Deductible	None
Advanced Imaging Services** (Outpatient-CT/PET, scans, MRIs)	$40 Copay After Deductible	None
Chemo, Infusion Therapy & Dialysis (Office)	$25 Copay After Deductible	None
Inpatient Surgery Physician & Surgical Assistant	Covered in Full After Deductible	None
Ambulatory/Outpatient Surgery**	$100 Copay After Deductible	None
Emergency Room (ER) Visit	$100 Copay After Deductible	None
Preadmission Testing	Covered in Full After Deductible	None
Anesthesia Services	Covered in Full After Deductible	None
Cardiac Rehab (Outpatient)	$40 Copay After Deductible	None
Urgent Care Centers	$25 Copay After Deductible	None
Gia® Virtual Care Services	Covered in Full After Deductible	
Ambulance (Emergency Medical Transportation)	$100 Copay After Deductible	None
Mental Health Inpatient Hospital	$250 Copay After Deductible	None
Service Category	In-Network Coverage	Limits and Exclusions

Mental Health Inpatient Hospital	$250 Copay After Deductible	None
Mental Health Outpatient	$25 Copay After Deductible	None
Substance Use Disorder Inpatient Hospital	$250 Copay After Deductible	None
Substance Use Disorder Outpatient	$25 Copay After Deductible	None
Maternity – Prenatal Care	Covered in Full After Initial $25 Copay After Deductible	None
Maternity – Physician Delivery	$200 Copay After Deductible	None
Maternity – Inpatient Hospital Services	$250 Copay After Deductible	None
Skilled Nursing Facility	Covered in Full After Deductible	120 days per year
Home Health Care	$40 Copay After Deductible	None
Hospice	Covered in Full After Deductible	None
Durable Medical Equipment (DME)	20% Coinsurance After Deductible	None
Diabetic Supplies & Equipment	20% Coinsurance After Deductible	None
Prescription Drug Coverage (OptumRx)		
Prescription Drug Deductible	Not Applicable	None
Generic Drugs	Retail: $10 Copay Mail Order: $25 Copay	
Preferred Brand Drugs	Retail: $25 Copay Mail Order: $62.50 Copay	None
Non-preferred Brand Drugs	Retail: $40 Copay Mail Order: $100 Copay	None
Specialty Drugs	As Applicable	None
Alternative Health		
Acupuncture Child Birth Classes Fitness Center Membership Fitness Equipment Fitness Classes and Training Sessions Homeopathic Hypnotherapy (weight control and smoking cessation) Massage Therapy Nutritional Counseling Weight Control Programs Acupuncture	100% Coverage up to $300 per year per covered employee/contract ($300 limit is the maximum benefit per contract per calendar year regardless of family size) Products purchased through these Programs are not covered	None
Frames, Lenses and Contacts	Individuals over 19: 50% up to $75 Maximum every 2 calendar years No dollar limit for children up to age 19	One (1) pair glasses every two (2) calendar years;
Routine Eye Exam	$40 Copay After Deductible	(1 exam every 2 calendar years)
Preventive Dental – For Children up to 19	Covered in Full After Deductible	(Exam, cleaning, bite wing x-rays, fluoride and sealants every 6 months)
Wigs $300 Max Per Member Per Lifetime	Covered in Full After Deductible	(Following Chemo Treatment)
Infertility Services (IVF, Gift, & Zift not covered)	Cost Share Determined by Service	None
Prosthetics / Orthotics	20% Coinsurance After Deductible	None
Chiropractic Benefit	$40 Copay After Deductible	None
Post Mastectomy Prosthesis	Covered in Full After Deductible	1 every year; 2 if Bilateral

*Deductible applies to this benefit. Some services are subject to notification or prior authorization requirements. See your Summary Plan Description for details.
Virtual care services from MVP Health Care are provided by UCM Digital Health, Amwell and Galileo at no cost-share for members. (Plan exceptions may apply.) Members' direct or digital provider visits may be subject to co-pay/cost-share per plan.
This plan overview is intended to provide a general outline of coverage. In the event of any conflict between this document and your SPD, the SPD will be controlling.
Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.